STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

May 2, 1986

ALL COUNTY INFORMATION NOTICE NO. I-44-86

TO: ALL COUNTY WELFARE DIRECTORS

SUBJECT: Medical Report CA 61 (4/86)

This transmits an advance copy of the revised Medical Report form, CA 61 (4/86). In making modifications to the form, state staff worked in cooperation with members of the CWDA Forms Subcommittee. The changes were designed to enhance question clarity, to elicit concise answers, and to increase the scope of client authorization to release information. A detailed list of the pertinent changes is attached to assist you.

The 4/86 version of the CA 61 will be available from the DSS Warehouse after the supply of the 2/84 version has been exhausted. You should continue to use your supplies of the 2/84 version; counties who print their own supplies of the CA 61 may utilize the 4/86 version upon receipt of this notice.

If you have any questions or suggestions regarding this form, you may contact Dennis Ragasa of the AFDC and Food Stamp Policy Implementation Bureau at (916) 324-2658 or ATSS 8-454-2658.

ROBERT A. HOREL
Deputy Director

Attachment

cc: CWDA

List of Changes to the CA 61

1. Added "One copy to: Client" in the distribution section.

2. Moved the "County Stamp" block to the upper right hand corner of the form.

3. Added "Etc" to the "Name of Physician/Hospital" line to expand the scope of client authorization to release information.

4. Added an address line for the "Physician/Hospital Etc." item and removed the "Physician's Address" box at the bottom of the form.

5. Added a sentence to the release statement which informs the client that the authorization is valid for one year and a copy is available upon request.

6. Modified the applicant signature area to enhance clarity and to improve ease of completion.

7. Deleted the "uncertain at this time" box from question 1.b of the 2/84 version to elicit a precise incapacity determination.

8. Added a "No appointment necessary" box to question 1.c to allow for situations in which the physician, etc. determines no further medical appointments are required.

9. Reworked question 2 (on the 2/84 version) to enhance question clarity by asking three specific "Yes" and "No" questions (new questions 2, 3 and 4). In addition, if question 2 or 3 is checked yes, an explanation is now required in the "Comments" section.

10. Changed the authorized signature block to read "Signature of Physician or Authorized Staff Member".

STATE OF CALIFORNIA
HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES

Distribution:
One copy to: County
One copy to: Physician
One copy to: Client

MEDICAL REPORT
AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

COUNTY STAMP

DISTRICT/UNIT	ELIGIBILITY WORKER	DATE

INSTRUCTIONS TO PHYSICIAN: *The AFDC applicant named below claims to be incapacitated. This report should provide the welfare department with an assessment of any medically verifiable condition(s) which would make the applicant unable to provide normal care for the child(ren), or prevent the applicant from accepting and/or keeping employment.*

Applicant and County: Please Complete This Section

I, _____ (NAME OF APPLICANT) hereby authorize _____ (NAME OF PHYSICIAN/HOSPITAL, ETC)

_____ (ADDRESS OF PHYSICIAN/HOSPITAL, ETC.)

to release the medical information requested by this form to the county welfare department. I also authorize the county welfare department to release the same information to the Department of Rehabilitation. This authorization is valid for one year and I may request a copy of this authorization.

SIGNATURE OF APPLICANT ▶	DATE

PATIENT'S NAME LAST	FIRST	MIDDLE	CASE NAME
AGES OF CHILDREN IN HOME			CASE NUMBER

Physician or Authorized Staff Member: Please Complete This Section

1. Medical Problem:
   a. Diagnosis and Prognosis

   b. Probable duration of incapacity: ☐ Permanent ☐ Temporary from _____, to _____
   (Please explain if you believe that further laboratory work or a more complete examination will be necessary before a judgment of the degree and permanence of the disability can be made.)

   c. DATE OF LAST EXAMINATION | DATE OF NEXT APPOINTMENT | ☐ No appointment necessary

2. Does this person's disability prevent him/her from working full-time at his/her regular job? ☐ YES ☐ NO

3. Does this person's disability prevent or substantially reduce his/her ability to care for the child(ren) in the home? ☐ YES ☐ NO

4. Does this person's disability require someone to be in the home to care for him/her? ☐ YES ☐ NO

COMMENTS: *(If 2 or 3 are checked yes, please explain the extent to which the person's condition prevents him/her from working or providing care for the child(ren) in the home.)*

SIGNATURE OF PHYSICIAN OR AUTHORIZED STAFF MEMBER ▶	TELEPHONE NUMBER ( )	DATE